DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 02 - 005
2. STATE: Minnesota
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2002

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.252

7. FEDERAL BUDGET IMPACT:
a. FFY '02 $ 150
b. FFY '03 $ 200

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Att. 4.19-A (Inpat. Hospital), pp. 1-53

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Att. 4.19-A (Inpat. Hospital), pp. 1-49

10. SUBJECT OF AMENDMENT:
Methods and standards for determining payment rates for inpat. hospital services provided by non-state owned facilities

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Mary B Kennedy

13. TYPED NAME:
Mary B. Kennedy

14. TITLE:
Medicaid Director

15. DATE SUBMITTED:
3/28/02

16. RETURN TO:
Stephanie Schwartz
Dept. Human Services
444 Lafayette Road No.
St. Paul, MN 55155-3853

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
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18. DATE APPROVED:
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PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2002

20. SIGNATURE OF REGIONAL OFFICIAL:
Cheryl A Harris

21. TYPED NAME:
Cheryl A. Harris

22. TITLE:
Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

RECEIVED
MAR 29 2002
DMCH/ARA

FORM HCFA-179 (07-92)

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MINNESOTA

MEDICAL ASSISTANCE

Federal Budget Impact of TN 02-05

Attachment 4.19-A: Inpatient Hospital Rate Methodology

Proposed State plan amendment TN 02-05 makes many "housekeeping" changes describing the rate methodology for non-state owned or operated inpatient hospitals, and one substantive change.

1. Section 2.0:

   A. Definition of ancillary service. The proposed change is necessary to increase precision in Minnesota's costing of ancillary services recognized on claims and the Medicare cost report, which is the basis for determining allowable base year costs for rate setting. Breaking out certain cost categories previously contained within other categories--costs for electrocardiology and electroencephalography were previously included in costs for radiology; costs for respiratory therapy, physical therapy, occupational therapy, and speech therapy were previously included in therapy; and costs of intravenous therapy were previously included in pharmacy--enhances the precision of determining the costs of individual claims. Similarly, observation bed services were previously costed by the emergency room and outpatient clinic cost category. Determining the cost of individual claims with more precision in turn affects the accuracy and validity of rate setting.

   Because these proposed new ancillary service categories are listed separately as a cost center on the Medicare cost report, establishing them as separate ancillary services with their corresponding Medicare cost-to-charge data will not require any additional work by either the hospitals or by the Department. Many hospitals establish physical therapy, occupational therapy, speech therapy and respiratory therapy as separate cost centers on the Medicare cost report, and it is very common for hospitals to have observation beds as a separate cost center on the Medicare cost report. Similarly, it is reasonable to show electrocardiology and electrocephalography as ancillary services separate from radiology because so many hospitals have established cost centers specific to these two services on the Medicare cost report.

   Although listed as a separate cost center on the Medicare cost report, intravenous therapy is not often used by hospitals. Hospitals that do not have such a cost center identified on the Medicare cost report usually have the costs for intravenous services included in pharmacy. Therefore, they are combined.

   B. Definition of city of the first class. Defining city of the first class is necessary because the term is used in determining whether a hospital is eligible for the small rural payment adjustment in Section 15.03.

C. Definition of long-term care hospital. This is added to clarify the current use of "long-term hospital" in this Attachment.

2. Section 3.0, page 28:

A. Current items B and C are deleted because they are no longer necessary. They describe the base year to be used for the children's hospitals and for the only long-term care hospital that existed for the 1993 rate year. The difference in base years for these hospitals was temporary and was updated slowly until the base years of other hospitals came within the same period. Now that that has occurred, it is no longer necessary for these items to be retained.

B. New item B describes how the base year for a long-term care hospital opening after April 1, 1995 is determined.

3. Section 4.0, pages 29-31:

A. Section 4.01, item B, subitem (2). This change substitutes a citation for several words, but does not change the meaning of the item.

B. Section 4.01, item B, subitem (4). This change clarifies that claims paid to long-term care hospitals are to be excluded in determining relative values.

C. Section 4.01, item B, subitem (7). This item cites to Section 15.11, which sets out the payment methodology for inpatient hospital stays longer than 365 days. Payment under section 15.11 is excluded in the determination of relative values and the applicable hospital's adjusted base year operating cost per admission, per day outlier, and the property cost per admission (DRG rate setting) because those services are paid under a different methodology. If the costs of those services were included in the DRG rate setting, it would result in a hospital getting paid twice. That is, the hospital would get paid once with the percentage of billed charges methodology and again when the costs of those services are included in the DRG rate setting.

D. Section 4.01, item C. At one time, the base year (1987/88) claims for newborn deliveries combined the mother's and the newborn's services into one claim. Current policy requires separate payment for the mother and the newborn.

E. Section 4.01, item D, subitem (2). New language clarifies that the ancillary cost-to-charge ratios must be adjusted according to a hospital's election for the payment of certified registered nurse anesthetist services. Current State plan language has similar language in Section 5.01, item A (determination of the adjusted base year operating cost per admission), Section 6.01 (determination of the adjusted base year operating cost for a neonatal transfer), and Section 6.05 (determination of the base year operating cost per

day for a long-term care hospital).

F. Section 4.01, item D, subitem (4). This is deleted because it is no longer current policy. At one time, only 8.5 percent of the base year malpractice insurance costs were included in a hospital's base year general and administrative cost center on the Medicare cost report that gets allocated to the accommodation and ancillary services. Therefore, it was necessary to allocate the remaining 91.5 percent of costs to a hospital's base year so a hospital would receive full recognition for malpractice insurance costs. However, the reporting of malpractice insurance costs has changed. The current base year now has all malpractice insurance costs included in the general and administrative cost center that is allocated to the accommodation and ancillary services.

G. Section 4.01, items F-J. These items have been amended to include the phrase "the rehabilitation distinct part." The addition is necessary because determining the relative values for the other specialty group, transfers to a neonatal intensive care unit, is not done in Section 4.0. The revisions provide clarity. The relative value determinations for the neonatal transfers are calculated in Section 6.0.

4. Section 5.0, pages 31-34:

A. Section 5.01. Throughout this section, changes are made to clarify that admissions are identified by program and specialty group. The changes describe how per admission rates are established for hospitals that have a rehabilitation distinct part specialty group.

Language regarding the adjustment to the cost-to-charge ratios for ancillary services according to a hospital's election for the payment of certified registered nurse anesthetist services is deleted because the changes in Section 4.01, item D (formerly item E), subitem (2) makes this language redundant.

B. Section 5.02. The phrase "the rehabilitation distinct part specialty group" is added for clarification. In addition, adjusted base year operating cost per day outlier is calculated for hospitals that have a rehabilitation distinct part specialty group.

C. Section 5.07. "Out-of-area" is added to better describe the type of hospital that can not be paid separately for certified registered nurse anesthetist services.

The deletions regarding the inability to select an alternative outlier percentage under sections 5.03, 5.04, or 5.05 remove material that is no longer relevant. First, the reference to Section 5.03 for out-of-area hospitals is not applicable because only Minnesota and local trade area hospitals have the ability to select an alternative outlier percentage. Secondly, an alternative outlier percentage is not applicable to Sections 5.04 and 5.05. These sections govern payments to Minnesota and local trade area hospitals

that do not have enough admissions in the base year for hospital-specific rate setting. These hospitals are paid on averages based on location, and on other hospitals' costs and outlier selections.

Because cost outliers are no longer used in this Attachment, "an alternative outlier percentage" is deleted.

5. Section 6.0, pages 34-36:

   A. Section 6.01, item (1). Deleted is language regarding the adjustment to the cost-to-charge ratios for ancillary services according to a hospital's election for the payment of certified registered nurse anesthetist services. It is deleted because the language refers to the change proposed in Section 4.01, item D, subitem (2) (formerly item E, subitem (2)).

   B. Section 6.01, subitems (3)-(5). The proposed changes provide further detail on determinations of the adjusted base year operating cost per day and do not change current practice.

   C. Section 6.05, item A. The changes correct citations and are technical. Language regarding the adjustment to the cost-to-charge ratios for ancillary services according to a hospital's election for the payment of certified registered nurse anesthetist services is deleted because the changes in Section 4.01, item D (formerly item E), subitem (2) makes this language redundant.

6. Section 7.0, pages 36-37:

   A. Section 7.02. The proposed changes comply with state law. Historically, in even-numbered years (years that the Department does not rebase rates), the HCI (hospital cost index, Section 7.0) was used to inflate the prior rate year's operating payment rate. However, as of calendar year 2002, Minnesota Statutes, §256.969, subdivision 1(b) does not permit the HCI to be used to inflate the prior rate year's operating payment rate unless enabling legislation is enacted.

   No such legislation was enacted in 2001. Therefore, Section 7.02 is amended.

7. Section 8.0, pages 37-39:

   A. Section 8.01, item D, subitem (3). The change clarifies that the Minnesota and local trade area property cost per admission is applicable by program and the rehabilitation distinct part specialty group.

8. Section 10.0, pages 41-42:

   A. Sections 10.01. The reference to the core hospital adjustment is deleted. Please see the discussion of deleted Section 15.06.

B. Section 10.02, item A. The reference to the core hospital adjustment is deleted. Please see the discussion of deleted Section 15.06.

C. Section 10.02, item B: New Section 15.11 establishes a payment methodology for services provided beyond 365 days. The services for the first year would be paid the rate per admission and outlier rate per day. The amendment specifying that the days paid under Section 15.11 is necessary to clarify that the outlier rate per day payments are not applicable for services after the first year, thus avoiding double payments for those services.

D. Section 10.03, item C: Pursuant to Section 15.08, the Department contracts with a few hospitals to provide inpatient hospital psychiatric services to recipients with serious and persistent mental illness who have been civilly committed or voluntarily hospitalized in lieu of commitment.

Pursuant to state law, the Department negotiates a rate per day payment for these recipients who would otherwise be transferred to a state hospital. It is common for such recipients to be admitted to a hospital during the time application is made for court commitment. This amendment provides for payment for the admission prior to commitment. If the recipient is committed and transferred (defined in Section 2.0 as the movement of a patient after admission from one hospital directly to another hospital with a different provider number or to or from a rehabilitation distinct part) to a contracting hospital (the admission hospital and the contracting hospital may be the same), the admission prior to the commitment is subject to the transfer rate per day payment.

The transfer is to a contracting hospital that provides state hospital-like services. However, a state hospital, because it is state-owned, is not subject to this Attachment. Because the discharge is for services that are not covered under this Attachment, it is reasonable to exclude such admissions from the transfer rate per day formula and make payment at a rate per admission. This is not a change to current practice.

C. Section 10.04 item C: "Without regard to relative values" is added to clarify that relative values are not used in the determination of long-term care hospital payments because, pursuant to Section 4.01, item (B), subitem 4, claims paid to long-term care hospitals are excluded in determining relative values. This is not a change to current practice.

9. Section 14.0, pages 46-47: Item B is amended to clarify that Medicare crossovers are excluded from an appeal. Medicare is the primary payer for Medicare crossovers that are paid under the rates of the Medicare program, while Medicaid is the secondary payer and is responsible for deductibles and coinsurance established under Medicare. Medicare crossovers are excluded from rate setting under Section 4.01, item B, subitem (1). It is reasonable to exclude claims in the case mix appeal that are not paid by rates determined under these rules.

It is necessary to exclude admissions that have a value of zero as their DRG. Because a relative value must be determined for each of the more than 500 DRGs, it is possible that there may not be any admissions in a DRG, especially for a new one that is created when revisions are made annually to the Medicare DRGs. Because a relative value can not be created, it is reasonable to exclude these admissions. This is not a change to current practice.

10. Section 15.0, pages 47-53:

A. Section 15.06. This section is deleted because it only applied to admissions occurring from July 1, 1993 to June 30, 1995.

B. Section 15.11, page 53: This Section proposes a new method of payment that would apply only to admissions with a length of stay exceeding 365 days. The first 365 days of services will be paid the current applicable rate per admission and outlier rate per day. Services provided on or after day 366 will be paid an amount approximating the hospital's actual costs.

The payment amount would be determined by multiplying the covered billed charges by the operating cost-to-charge ratio determined in the hospital's base year admissions used for relative value determination under Section 4.01, item D.

The new method for determining payments for services provided for more than 365 days replaces the current method of paying a DRG outlier rate per day. The new method will not often apply because lengths of stay that exceed a year are very rare.

The DRG classification system was designed for short-term acute care hospital admissions. Patients are grouped by diagnostic similarities with the expectation that similarity in their intensity of resource use will follow. Typically, patients are admitted for the evaluation and treatment of disease and are discharged from acute care once the evaluation and treatment of the disease in its acute stage is completed. Admissions for which hospitals are paid a rate per admission under this rule reflects the typical pattern; five days is the average length of stay.

It is unlikely that one DRG will adequately reflect the resource utilization and the dynamic medical needs for patients with diseases or conditions severe enough to require hospitalization for more than a year. A patient's classification by DRG can be determined only after the patient is discharged because determination must be based on knowing all the diagnostic and procedural codes that applied during the patient's hospitalization. For the occasional long-term stay paid under the rule parts, hospitals are allowed to submit interim bills every 30 days so that hospitals will receive payments throughout the long-term stay, rather than having to wait for payment until the patient is discharged.

An interim bill reflects diagnostic and procedural codes that began being applied at the patient's admission. When the long-term stay is completed and the patient is discharged, the codes submitted on the interim bills are typically not the same as the codes submitted on the final bill. Applying a payment method that realistically approximates actual costs for a stay of five days does not approximate actual costs nearly as well for a stay of over 365 days. Consequently, either underpayment or overpayment is likely to occur.

It is reasonable to use 366 days as the point of departure for applying the new payment method because payments for admissions with a length of stay between 180 days and 365 days can be calculated reasonably realistically under a DRG payment system. As with the number of admissions with lengths of stay exceeding 365 days, a length of stay of between 180 days and 365 days is rare.

It is also reasonable for the new payment methodology to exclude admissions paid on a rate per day basis. A rate per day payment system recognizes extreme variances in length of stay and is a better predictor than a rate per admission of the resources needed to provide the inpatient hospital services. Although DRGs are used to classify transfers to a neonatal intensive care unit, payment under Section 6.01 is made on a rate per day. Similarly, inpatient hospital services provided by a long-term care hospital are paid on rate per day under Section 6.05.

	FFY '02*	FFY '03
Total cost	$300,000	$400,000
FFP	50.00%	50.00%
Total MA Cost	$300,000	$400,000
State share	$150,000	$200,000
Federal share	**$ 150,000**	**$200,000**

* January 1, 2002 through September 30, 2002

Methods and Standards for Determining Payment Rates for Inpatient Hospital Services Provided by Non-State Owned Facilities

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SECTION 1.0 PURPOSE AND SCOPE

The Minnesota inpatient hospital payment system under the Medical Assistance Program is authorized by state law. Payment rates are prospectively established on a per admission or per day basis under a diagnostic related group (DRG) system that condenses Medicare categories into Minnesota diagnostic categories. Rates are differentiated by eligibility (Medical Assistance, Minnesota Family Investment Program or MFIP, Medical Assistance non-MFIP) and specialty (Rehabilitation Distinct Part, Neonatal Transfer). The system provides for the payment of operating and property costs with additional payments including a disproportionate population adjustment and an appeals mechanism.

The rate setting methodology is based on the cost finding and allowable cost principles of the Medicare program. The rates are established for each calendar year using hospital specific Medical Assistance claims data and cost that is trended for inflation to the current year from a base year. Rates are rebased to more current data every two years.

The methodology described in this Attachment is effective for admissions occurring on or after October 25, 1993.

To be eligible for payment, inpatient hospital services must be medically necessary.

Minnesota has in place a public process that complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

SECTION 2.0 DEFINITIONS

Accommodation service. "Accommodation service" means those inpatient hospital services included by a hospital in a daily room charge. They are composed of general routine services and special care units. These routine and special care units include the nursery, coronary, intensive, neonatal, rehabilitation, psychiatric, and chemical dependency units.

Adjusted base year operating cost. "Adjusted base year operating cost" means a hospital's allowable base year operating cost per admission or per day, adjusted by the hospital cost index.

Admission. "Admission" means the time of birth at a hospital or the act that allows a recipient to officially enter a hospital to receive inpatient hospital services under the supervision of a physician who is a member of the medical staff.

Allowable base year operating cost. "Allowable base year operating cost" means a hospital's base year inpatient hospital cost per admission or per day that is adjusted for case mix and excludes property costs.

Ancillary service. "Ancillary service" means inpatient hospital services that include laboratory and blood, radiology, anesthesiology, electrocardiology, electroencephalography, pharmacy and intravenous therapy, delivery and labor room, operating and recovery room, emergency room and outpatient clinic, observation beds, respiratory therapy, physical therapy, occupational therapy, speech therapy, medical supplies, renal dialysis, and psychiatric; and chemical dependency services customarily charged in addition to an accommodation service charge.

Base year. "Base year" means a hospital's fiscal year that is recognized by Medicare, or a hospital's fiscal year specified by the commissioner if a hospital is not required to file information with Medicare, from which cost and statistical data are used to establish rates.

Case mix. "Case mix" means a hospital's admissions distribution of relative values among the diagnostic categories.

Charges. "Charges" means the usual and customary payment requested by the hospital of the general public.

City of the first class. "City of the first class" means a city that has more than 100,000 inhabitants, provided that once a city is defined in such a manner, it can not be reclassified unless its population decreases by 25 percent from the census figures that last qualified the city for inclusion in the class.

Cost outlier. "Cost outlier" means the adjustment included in the relative value that is applied to the admission and outlier rates so that payment is adjusted for exceptionally high cost stays. The adjustment is applied to all admissions with an above average cost, including patients that have not yet attained the age of one in all hospitals and that have not yet attained the age of six in disproportionate population hospitals.

Cost-to-charge ratio. "Cost-to-charge ratio" means a ratio of a hospital's inpatient hospital costs to its charges for inpatient hospital services.

Day outlier. "Day outlier" means an admission where the length of stay exceeds the mean length of stay for neonate and burn diagnostic categories by one standard deviation, and in the case of all other diagnostic categories by two standard deviations.

Diagnostic categories. "Diagnostic categories" means the diagnostic classifications containing one or more diagnostic related groups (DRGs) used by the Medicare program. The DRG classifications must be assigned according to the base year program and specialty groups with modifications as specified in items A to E.

A. Diagnostic categories eligible under the Medical Assistance non-Minnesota family investment program. The following diagnostic categories are for persons eligible under Medical Assistance non-MFIP except as provided in items B, C or D:

DIAGNOSTIC CATEGORIES	DRG NUMBERS WITHIN DIAGNOSTIC CATEGORIES	INTERNATIONAL CLASSIFICATION OF DISEASES, 9th Ed. CLINICAL MODIFICATIONS
A. Nervous System Conditions		
(1) Treated with Craniotomy, Age >17	001, 002	
(2) Treated with Craniotomy, Age 0-17	003	
(3) [Reserved for future use]		
(4) [Reserved for future use]		
(5) [Reserved for future use]		
(6) Nervous System Neoplasms	010, 011	
(7) [Reserved for future use]		
(8) [Reserved for future use]		
(9) [Reserved for future use]		
(10) [Reserved for future use]		
(11) [Reserved for future use]		
(12) [Reserved for future use]		
(13) [Reserved for future use]		
(14) [Reserved for future use]		
(15) [Reserved for future use]		
(16) Treated with Other Surgical Procedures	004, 005, 007	
(17) Peripheral, Cranial, and Other Nerve Procedure without CC	008	
(18) Other Nervous System Diseases Treated Without Surgery	013, 015, 017	
(19) Spinal Disorders/Injuries and Nervous System Infection	009, 020	
(20) Specific Cerebral Vascular and Cranial/Peripheral Nerve Disorders	014, 018, 019	
(21) Degenerative and Nonspecific Cerebral Vascular Disorders with CC	012, 016	
(22) Seizure and Headache	024-026	

(23) Traumatic Stupor with Coma > 1 Hr, and Coma < 1 Hr, Age > 17 with CC	027, 028	
(24) Viral Meningitis, Hypertensive Encephalopathy, Concussion Age > 17 with CC, Other Stupor and Coma	021-023, 029, 031	
(25) Concussion, Age 0-17 and Age > 17 without CC	032, 033	
(26) Stupor and Coma < 1 Hr, Age 0-17 and Other Disorders of the Nervous System	030, 034, 035	
B. Eye Diseases and Disorders	036-048	
C. Ear, Nose, Throat, and Diseases and Disorders		
(1) Treated with Tonsillectomy/ Adenoidectomy Only	059, 060	
(2) Treated with Myringotomy with Tube Insertion, Age 0-17	062	
(3) Otitis Media and URI	068-070	
(4) Dental and Oral Disorders	185-187	
(5) [Reserved for future use]		
(6) Other Ear, Nose, Throat and Mouth Conditions	049-058, 061, 063-067, 071-074, 168, 169	Codes in DRG 049 except 20.96-20.98
D. Respiratory System Conditions		
(1) Treated with Ventilator Support for < 96 Hours	475	Excludes 96.72
(2) [Reserved for future use]		
(3) Treated with Ventilator Support for 96 + Hours	475	Includes 96.72
(4) Treated with Tracheostomy Except For Face, Mouth, and Neck Diagnoses	483	
(5) [Reserved for future use]		
(6) Respiratory Neoplasms	082	
(7) [Reserved for future use]		
(8) [Reserved for future use]		
(9) [Reserved for future use]		
(10) Treated with Tracheostomy for Face, Mouth, and Neck Diagnoses	482	
(11) Simple Pneumonia and Pleurisy, Age 0-17 and Age >17 without CC	090,091	
(12) Major Chest Procedures and OR		

	Procedures with CC	075, 076
(13)	Major Respiratory Diseases and Disorders Treated with Surgery	078, 079, 087, 092, 101
(14)	Other OR Procedures without CC	077
(15)	Specific Respiratory System Diseases and Other Diseases with CC	080, 081, 083, 085, 088, 089, 094, 099
(16)	Respiratory System Diseases without CC and Bronchitis, Age >17	084, 086, 093 095-097, 100, 102

E. Circulatory System Conditions

(1)	[Reserved for future use]	
(2)	[Reserved for future use]	
(3)	Percutaneous Cardiac and Other Vascular Procedures	111, 112, 114,116-120, 479
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(7)	[Reserved for future use]	
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(2) [Reserved for future use]		
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(7) Disorders of the Biliary Tract	207, 208	
(8) Treated with Surgical Procedure	191-201, 493 494	Codes in DRG 191 except 52.80-52.86

H. Diseases and Disorders of the Musculoskeletal System and Connective Tissues

(1) Treated with Major Joint and Limb Reattachment Procedures	209, 472, 491	
(2) Treated with Hip and Femur Procedures or Amputation	210-213	
(3) [Reserved for future use]		
(4) [Reserved for future use]		
(5) Treated with Wound Debrid or Skin Graft Except Hand	217	
(6) Treated with Lower Extrem and Humer Proc Except Hip, Foot, Femur	218-220	
(7) [Reserved for future use]		
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(11) [Reserved for future use]		
(12) [Reserved for future use]		
(13) [Reserved for future use]		
(14) [Reserved for future use]		
(15) Other Musculoskeletal System and Connective Tissues Conditions	235-256	

(16)	[Reserved for future use]		
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(21)	Hand and Wrist Procedures and Carpal Tunnel Release	006, 228, 229	
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(23)	Arthroscopy, Other Back and Neck Procedures without CC	232, 500	

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(3)	Diabetes, Age 0-35	295	
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(1)	[Reserved for future use]	
(2)	[Reserved for future use]	
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O. [Reserved for future use]

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(4)	Red Blood Cell Disorders, Age 0-17	396
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(3)	[Reserved for future use]	
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(5)	[Reserved for future use]	
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S. Mental Diseases and Disorders

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U. [Reserved for future use]

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(2)	[Reserved for future use]	
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(2)	[Reserved for future use]	
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Z. [Reserved for future use]

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BB. [Reserved for future use]

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(1)	[Reserved for future use]	
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EE. [Reserved for future use]

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JJ. [Reserved for future use]

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(2) [Reserved for future use]		
(3) [Reserved for future use]		
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